September 5, 2006

Beth Tanzman, MSW
State of Vermont
Department of Health
Division of Mental Health
108 Cherry Street
P.O. Box 70
Burlington, Vermont 05402-0070

RE: Docket # 06-013-H
Application for Conceptual Certificate of Need to create new inpatient programs to enhance psychiatric inpatient care and replace the functions currently performed by Vermont State Hospital

Dear Beth,

Thank you for the application, received here and filed on August 17, 2006, seeking a Certificate of Need (CON) to permit the Vermont Department of Health (VDH) to be authorized "to carry out feasibility analyses of multiple options and to develop detailed plans for the most feasible models" to replace the functions currently performed by Vermont State Hospital[1] and to permit VDH to "incur planning expenditures to analyze and compare the feasibility of various options for the replacement of the Vermont State Hospital"[2]. Such a CON, commonly referred to as a conceptual CON, is required for projects anticipated to cost in excess of $20,000,000 before entities may "make expenditures for architectural services, engineering design services, and any other planning services needed in connection with the project".[3]

Please respond to the following questions and requests for additional information and clarifications. When submitting your responses, please use the same numbering scheme and restate our question verbatim followed by your answer. To facilitate your response in such a format I have also sent you an electronic copy of this letter in Word format. Subsequent questions by our Department (BISHCA) will be assigned new, sequential numbers for ease of reference. Please also be sure to provide copies of your responses to all of the interested parties.

[1] Application, page 1
[2] Application, page 81
[3] 18 V.S.A. §9434(e)

In an effort to expedite the process, our Department has endeavored to both submit questions to you quickly and to ask as many questions as we have at this time. Further review of the application will likely produce more questions, however, as will review of VDH's responses to the questions below.

Please also note that it is possible that the answer to some of the questions below may be that VDH will use a conceptual CON to study the matters described and develop specific information that will then be provided in the second CON (Phase II) process. Please specifically identify such instances. Some of the questions below anticipate that scenario but VDH may find other questions that also fit that category.

References to the application will be indicated below by page numbers cited in parentheses. Buildings that would be constructed or renovated and in which patients would receive services will usually be referred to below as "facilities". The services provided to patients in facilities will usually be referred to below as "programs" or "programming." Health care that is not intended to primarily address mental health or substance abuse diagnoses will usually be referred to below as "physical health care". The applicant will usually be referred to below as "VDH" or the "State".

1. Please provide documentation and/or research supporting the statement that "The treatment of acute mental illness is increasingly integrated with medical and general inpatient services" (p.1)

2. Please provide documentation and/or research specifying what is required for treatment of acute mental illness to be considered "integrated with medical and general inpatient services" Does such integration require services to be provided:
    a. By the same entity?
    b. By the same staff?
    c. In the same building?
    d. On the same campus?
    e. Pursuant to the same policies and procedures?
    f. Using the same clinical standards?

    Please explain.

3. Please specify what planning VDH will do, if it is granted a Conceptual CON, with which to meet its burden of proving, in the second (Phase II) CON application, that the "project will create new community mental health service capacities to reduce Vermont's reliance on involuntary inpatient psychiatric care."

4. The application indicates it seeks authorization to "carry out feasibility analyses of multiple options and to develop detailed plans for the most feasible models." (p. 1.)
    a. What will such feasibility analyses consist of?
    b. How will VDH determine which, and how many, "multiple options" will be analyzed?
    c. How does VDH define "feasible"?
    d. Specifically with respect to financial feasibility,

i. What is VDH's total budget, or budget range, available or reasonably anticipated to be available, for capital construction for the replacement of the services currently provided at VSH?
ii. What is the total budget, or budget range, available or reasonably anticipated to be available, for operating expenses for the replacement of the services currently provided at VSH?

5. The application indicates VDH seeks permission to incur planning expenditures to analyze and compare the feasibility of "various options" (p. 2) for the replacement of the Vermont State Hospital but appears to reference only one option consisting of three components with possible variations of the construction plans within those components: construction of an inpatient psychiatric facility on the Burlington campus of Fletcher Allen Health Care (FAHC), renovation and expansion of the inpatient psychiatric facility on the campus of Rutland Regional Medical Center (RRMC), and some undefined expansion on the campus of Retreat Healthcare (Retreat).
    a. Is this the extent of the "various options" VDH intends to incur planning expenditures to analyze?
    b. If so, what would VDH do if all or part of this plan proves not to be feasible?
    c. If not, how will VDH determine what other options to explore as part of its analyses?

6. The application indicates the preferred options would be "under the license" of FAHC, RRMC and the Retreat.
    a. Under what entity's license are the current services provided?
    b. Why are the services currently provided under such license and by what authority?
    c. Why does VDH plan to have the replacement programs provided under the licenses of FAHC, RRMC and the Retreat?
    d. Could the replacement programs be provided under the same license as the current VSH without negative financial or programmatic impact? Explain

7. The Civil Rights of Institutionalized Persons Act[4] (CRIPA) protects against deprivations of rights, privileges or immunities of persons residing in or confined to an institution which is "owned, operated, or managed by, or provides services on behalf of any State or political subdivision of a State" and which is "for persons who are mentally ill, disabled, or retarded, or chronically ill or handicapped;…" It permits initiation of civil actions by the Attorney General whenever he or she has reasonable cause to believe that "any State or political subdivision of a State, official, employee, or agent thereof, or other person acting on behalf of a State or political subdivision of a State is subjecting persons residing in or confined to an institution" to deprivation of rights.
    a. Would patients served by the replacement facilities proposed by VDH be protected by CRIPA even if those facilities are operated under the licenses of private entities? Please explain.

[4] 42 U.S.C. §1997 et seq.

8. The application indicates the "preferred options" include creating "a 40 bed stand alone psychiatric hospital on or off the Burlington campus" of FAHC (p. 2), 6 new psychiatric inpatient beds at RRMC, and up to four psychiatric inpatient beds at the Retreat.
    a. This appears to differ somewhat from BISHCA's previous understanding of the number of beds VSH plans to locate at FAHC and what the preferred location at FAHC is. Please explain.
    b. Explain the methodology used to determine that 6 beds are the appropriate number to add at RRMC.
    c. Explain the methodology used to determine that up to 4 beds are the appropriate number to add at the Retreat.

9. The application indicates that if new capacities at RRMC and the Retreat prove not to be feasible the number of beds planned for the primary program with FAHC could be increased.
    a. Provide all information VDH is aware of that indicates limitations on how many beds FAHC can accommodate on the Burlington campus and/or on any other campus.
    b. Specifically, what are the limits to the numbers of such beds that can be added at FAHC's campuses?
    c. If adding any or all new capacities at FAHC prove not to be feasible what would VDH do to meet the need?

10. The application references advantages of providing psychiatric care at a tertiary level hospital (see p. 3 for example). Please specify these advantages and indicate how they directly relate to specific deficiencies at VSH.

11. RRMC and the Retreat are not tertiary level hospitals. Given your response to question 10 above, why would it be appropriate to provide care to some portion of the population served by VSH at FAHC but provide care to the rest of the population at less than tertiary level facilities?

12. Page three of the application specifies core policy considerations driving the concept of replacing VSH. These include "integration of psychiatric inpatient care with general inpatient care", co-locating "all of Vermont's tertiary-level psychiatric inpatient care with Vermont's only tertiary hospital" and developing "new community capacities" to reduce Vermont's reliance on inpatient care…"
    a. How does VDH define the integration of psychiatric inpatient care with general inpatient care?
        i. How does VDH expect this could be accomplished on the Burlington campus of FAHC?
        ii. How does VDH expect this could be accomplished on any other FAHC campus?
        iii. How does VDH expect this could be accomplished on the RRMC campus?
        iv. How does VDH expect this could be accomplished on the Retreat's campus?

b. Please define tertiary level psychiatric inpatient care. How does that term relate to the application's use of the following categories (please note these terms were derived from reviewing the application and are worded in such a way as to hopefully best capture the nomenclature used by VDH. They are intended to be descriptive, informative and inclusive rather than exclusive. If, for example, VDH does not define crisis diversion beds as "mental health crisis diversion beds" please respond as best possible. If it is necessary to make distinctions between such terms please do so and explain):
    i. Intensive care psychiatric beds/units
    ii. Specialized inpatient psychiatric beds/units
    iii. General hospital psychiatric beds/units
    iv. Mental health crisis beds/units
    v. Mental health crisis diversion/triage beds/units
    vi. Secure residential beds/facility
    vii. Sub-acute beds/facility
c. How will VDH use planning authorization granted in a conceptual CON to develop, define, and describe the "new community capacities" that would be implemented as part of the plan?

13. The application indicates that "all of Vermont's hospitals" were invited to an information session on August 31, 2004. Dartmouth Hitchcock Medical Center (DHMC) is a tertiary level academic medical center serving significant portions of Vermont and which derives significant revenues from Vermont. It also has an inpatient psychiatric program and engages in many collaborations, joint ventures, and alliances with several Vermont hospitals and other health care providers.
    a. Was DHMC invited to the referenced information session or any similar initiative?
    b. If so, what was the result?
    c. If not, why not?

14. Please provide documentation of all initiatives to invite hospitals to participate in providing services as part of a plan to replace VSH. Please include all letters, agendas, reports, and other documentation reflecting the VDH's efforts in this regard and the responses by the hospitals.

15. The application indicates (see, e.g. p. 4) that the Retreat is an Institution for Mental Disease (IMD). The application also notes the importantance of partnering with institutions, when replacing VSH, in such a way as to ensure the VSH replacement programs do not prevent the receipt of federal funds due to the IMD exclusion.
    a. Will the services provided by the Retreat as part of the plan proposed by VDH be entitled to federal funding or will such services be barred from federal participation because of the Retreat's status as an IMD?
    b. If such services to be provided at the Retreat would not permit federal funding why does VDH propose partnering with the Retreat?
    c. If such services can be provided at the Retreat in a manner to enable federal funding despite the Retreat's IMD status, why is this? And, if so, could such a

process to receive federal funds at an IMD apply to other IMD's now existing or that might be created within the State?

d. Please explain and document any and all communications VDH has had with the Centers for Medicare and Medicaid Services, or any other appropriate or relevant entity, regarding the IMD funding issue.
e. At the June 20, 2006 Mental Health Oversight Committee hearing VDH indicated there might be ways to obtain federal participation for the beds at the Retreat despite its IMD status. Please explain.

16. Does, and if so, why does, VDH continue to support the recommendation referenced on page 5 that "an in-patient facility of up to twenty-eight (28) beds, including eight (8) psychiatric intensive care unit (ICU) beds" should be (recognizing the numbers may have since been adjusted based on further information):
    a. co-located with a general hospital
    b. managed by a general hospital
    c. governed by a general hospital

17. The recommendations of the VSH Futures Advisory Committee work group on the inpatient setting and partner options are represented on pages 5-6 as calling for a primary site and one or two smaller inpatient capacities created for "geographic accessibility with close coordination, clinical collaboration, and common standards for consistency."
    a. How is geographic accessibility defined?
    b. How is close coordination defined?
    c. How is clinical collaboration defined?
    d. What is meant by "common standards for consistency"?
    e. Does VDH now have a plan to achieve such accessibility, coordination, collaboration and standards?
        i. If so, please explain
        ii. If not, please indicate how a conceptual CON would be used to develop such a plan

18. The recommendations of the VSH Futures Advisory Committee work group on the inpatient setting and partner options as represented on pages 5-6 indicate the primary VSH replacement facility should not be an IMD.
    a. Does this mean it would be acceptable for the secondary sites to be IMDs? Why or why not?

19. The recommendations of the VSH Futures Advisory Committee work group on the inpatient setting and partner options as represented on pages 5-6 indicate the primary VSH replacement site must be a designated hospital. Subsequently, VDH determined the secondary VSH replacement sites must also be designated hospitals. Why?

20. Pages 6 and 7 of the application list criteria developed by the above-referenced work group.
    a. Are these a verbatim reproduction of the criteria as set forth by the work group? If not please explain.

b. How does/will VDH weigh these criteria when analyzing or investigating possible partners?
c. How does/will VDH weigh these criteria when analyzing or investigating possible sites?
d. Please provide a matrix indicating how each of the three partners identified to date, FAHC, RRMC and the Retreat, meet each of the prescribed criteria.

21. Please explain, with respect to the statement on page 7 regarding Springfield Hospital's status as a Critical Access Hospital (CAH), whether VDH is aware of any method, such as alternate licensing, by which inpatient psychiatric beds could be added to either the Springfield or Bellows Falls campuses (or a new campus) of Springfield Hospital in compliance with the CAH rules and/or in such a way as to permit federal financial participation despite the IMD rules. Please explain.

22. Regarding the discussion on page 8 regarding funding for VSH and for the community agencies, please explain:
    a. The sources of such funding
    b. The extent to which such funding is a "zero sum game" with increased resources for one coming at the expense of the other
    c. Perceived opportunities for or limitations on funding for both programs in the foreseeable future

23. What is the likelihood that the past negative financial pressures on VSH, described on page 10, would continue or re-occur in the future? Please explain.

24. Vermont's 14 not-for-profit community hospitals subsidize many of their programs that do not cover costs through revenues from other programs that cover costs and earn a margin. Furthermore, these hospitals cost shift from low reimbursing payers (generally, payers who pay less than cost) to higher reimbursing payers (who generally pay more than cost), usually commercial insurers. If replacement facilities for VSH are co-located on, managed by, and governed by some of these community hospitals:
    a. What is the risk that costs to cover the VSH replacement inpatient psychiatric programs will be subsidized by other hospital programs? Please explain your analysis.
    b. What is the risk that costs to cover the VSH replacement inpatient psychiatric programs will be shifted to other payers such as commercial insurers? Please explain your analysis.

25. The applicant proposes to make substantial capital improvements, using public funds, to the campuses of private institutions.
    a. What entity(ies) will own the resulting facilities?
    b. What entity(ies) will control the use of the resulting facilities?
    c. What rights will VDH have to require continued use of the resulting facilities for the VSH replacement programs?

26. Vermont's CON laws do not require that an entity, such as a hospital, obtain a CON before the discontinuance of a health care service. For example, FAHC would not need to obtain a CON to discontinue providing inpatient psychiatric services. The State's obligation to provide the inpatient psychiatric services described in the application is perpetual, however.
    a. Please explain how VDH will ensure the partners will continue to provide the needed services.
    b. Please explain how VDH will ensure the partners will continue to provide the needed services in the prescribed locations and according to the State's standards and needs.

27. Please explain the history of the Dale Unit at VSH and provide census data pre- and post-closing of the Dale unit to illustrate the impact on VSH's census. Please explain how VDH provided for the needs of the patients no longer served on that unit.

28. One of the advantages of providing inpatient psychiatric services in partnership with the state's community hospitals appears to be an ability to provide more appropriate and timely physical health care.
    a. Please explain how this is provided currently to patients at VSH
    b. How is it paid for?
    c. Please explain how it would be provided under the new model
    d. How would it be paid for?

29. Generally, tertiary hospitals, especially academic medical centers, have higher fixed costs than other hospitals..
    a. Has VDH examined this issue with respect to the physical health care that psychiatric in-patients would receive at FAHC?
    b. Has VDH examined this issue with respect to the mental health care that psychiatric in-patients would receive at FAHC?
    c. If so, what has VDH projected to be the nature of the resulting cost differential?
    d. If not, how does VDH plan to discern and weight this in planning for the Phase II CON?

30. Please present a proposed budget for expenses VDH anticipates incurring in preparation for filing the Phase II CON application, indicating expenditures by category.

31. The application indicates (p. 10) that pursuant to 18 V.S.A. §7205 the Department of developmental and mental health services (predecessor to the Division of Mental Health) operates the Vermont State Hospital.

    a. Please explain the authorities and roles of the Board of Mental Health (18 V.S.A. §7301) and the State Program Standing Committee.
    b. What role, if any, have they played or will they play in the proposals to replace VSH?

c. What role, if any, will they play in oversight, management or goverance of VSH replacement facilities?

32. The application indicates (p. 10) that Vermont's Public Mental Health Services system includes VSH, five designated hospitals, and 11 community agencies designated to provide services…"
    a. Please describe the governance of each such institution and explain the extent to which the State governs each institution and the extent to which non-state entities govern each institution.
    b. Has VDH determined how a relocation of the services provided at VSH to other facilities will impact governance and control? If so, please detail and explain, If not, please explain how and when this will be determined.

33. Please document the shift, described on page 11, beginning in 1994, in the number of involuntary admissions away from VSH as a result of partnerships with other entities.

34. By what authority or mechanism is the census at VSH capped at 54? Why?

35. Please provide a matrix providing more detail (perhaps by month and by entity) to the statement that diversion back to designated hospitals occurred approximately 30 times in the past two years.

36. Footnote 13 on page 10 indicates the community mental health centers are the lead agencies with respect to providing comprehensive services to Vermont's priority mental health population, including adults with severe mental illness.
    a. How do the CMHC's fulfill this role now with respect to the patients at VSH?
    b. How will the CMHC's fulfill this role if the proposed replacement plan is implemented?

37. The application indicates (p. 12) that an unintended consequence of Vermont's emphasis on community treatment has been "under-funding of VSH." Concerns about under-funding of the Futures plan are also evident in the application (see, e.g. the responses by the community mental health centers to the VDH's Request for Information). How does VDH intend to use a conceptual CON planning process to address the potential for under-funding of the VSH replacement programs and/or the community treatment programs?

38. The application (p. 12) indicates both the facility and the programming at VSH "had been such that the program did not meet accreditation standards and the safety of patients was considered at risk." Please explain:
    a. In what respects did/does the facility not meet accreditation standards?
    b. In what respects did/does the programming not meet accreditation standards?
    c. In what respects did/does the facility pose safety risks to patients?
    d. In what respects did/does the programming pose safety risks to patients?
    e. How replacement of the facility will resolve the problems presented in 39 (a) through 39 (d) above?

39. At pages 17-18 the application notes the special role VDH plays in serving particular populations and operating with a "no-reject" admissions policy. How will VDH ensure that successor entities provide the same level of services, maintain a no-reject policy, and serve all of the populations specifically described on pages 17-18?

40. Table 3 on page 19 appears to indicate a significant drop off in total admissions at VSH from 1998 to 1999 and continuing thereafter. Please explain.

41. The application indicates, on page 19, that 31 percent of the bed days had no source of payment in SFY04.
    a. How was this care funded?
    b. If the responsibility for providing the services is transferred to entities such as FAHC, RRMC and the Retreat, how will the cost for such care be determined and how will such care be funded?

42. What are the "contemporary standards" for care referenced on page 22 under "Clinical Considerations"? Please provide the source documents.

43. Has VDH researched how other states/entities provide care that meets such contemporary standards?
    a. If so, please provide the results of such research, indicating, for instance whether other states meet such standards by delivering care at the same site physical health care is provided at or at some other site in partnership with the site where physical health care is provided.
    b. If not, please describe how VDH will use the planning authority of a conceptual CON to conduct this research.

44. What is required, in terms of resources, location, facilities, etc., in order for professionals "to interact with their peers and stay current with emerging trends across the continuum of care" as stated on page 23 of the application? How is it done at other institutions providing quality care?

45. Please quantify and qualify the statement that "Increasingly, the patients admitted to VSH have complex medical conditions requiring treatment."

46. Please indicate the frequency that applies to the statement that "there was an average of 3 major, medical diagnoses per patient that required active treatment" from August 1999 to august 2000. For example, is this a per month statistic?

47. Which hospitals provided the 210 patient visits, 3,000 lab tests and 27 emergency room visits referenced on page 23?

48. What is the rate of co-occurring conditions among VSH patients (referenced on page 23) and how is it determined that this rate is "very high"?

49. How are co-occurring conditions defined?

50. Page 24 references the characteristics of a specialized inpatient unit, particularly the specialized staffing needed for such units. How have the current personnel at VSH, especially psychiatrists with special expertise, been recruited to work at VSH and what entities/partners provide them? Please provide documentation reflecting how VSH meets its staffing needs. If non State-owned hospitals or entities provide some of the staffing, whether professional, administrative, service or management, please specify the sources and provide relevant documentation.

51. Please document and provide source materials for the statement on page 25 that "specialized inpatient level of care must have easy access to general medical care".
    a. What constitutes "easy" access to general medical care?
    b. How is "general medical care" defined?
    c. Which hospitals provide such level of care to Vermonters?
    d. How is "general medical care" different from tertiary care?

52. What is the source, on page 25, of the defining characteristics of a "specialized inpatient service": "optimized for safety", "include[ing] single rooms, adequate space to allow for physical activity and exercise, and quiet areas to facilitate voluntary regaining of control over one's behavior"?

53. What is required, both in terms of facilities and programming, in order to achieve satisfactory levels of the characteristics referenced in question 52 above?

54. What is the source, on page 25, of the defining characteristics of "intensive care units (ICU)"?

55. What is required, both in terms of facilities and programming, in order to achieve satisfactory levels of the characteristics referenced in question 54 above?

56. Please detail the "distinguishing features of the ICU", providing any information you have to date that informs VDH as to standards, guidelines or recommendations VDH is aware of that indicate what the "size, configuration of physical space, monitoring capacity, higher registered nurse-to-patient ratios, and a staff with an enhanced skill set and experience" need to meet.

57. Please explain how replacing the buildings in which services are now offered is relevant to not "replicat[ing] trauma dynamics for patients and staff." (p. 25)

58. Please explain what is meant by "complex transport by ambulance or sheriff" as referenced on page 25. Provide relevant policies and elaborate by providing numbers of instances of transport broken out by means of transport, reasons for transport, and procedures followed for differing types of transport or reasons for transport. Please provide the information for the last three years, either fiscal or calendar.

59. What are the "secure, alternative Transportation options to the current system of using sheriffs" referenced on page 33 and what is the plan for achieving the "additional resources for transportation costs" that may be necessary "due to geographical distribution of programs."

60. Specifically referring to each of the preferred facility options, how will the transport issue referenced above be affected by the proposed replacement of VSH?

61. In what ways, specifically, do the community hospitals "currently lack the clinical and physical security capacity to provide the VSH level of care"? (p. 25)

62. The application, at page 25, indicates that in SFY 04 the operating cost for VSH was $13,520,510. Please provide:
    a. The operating costs for VSH for SFY 05 and SFY 06 and the projected operating cost for SFY 07
    b. The operating costs identified in 62a above calculated per adjusted admission
    c. The operating costs per adjusted admission, for comparable time periods, for the inpatient psychiatric programs at FAHC, RRMC and the Retreat
    d. Please explain factors that account for differences in the operating costs per adjusted admission of the programs at VSH, FAHC, RRMC and the Retreat

63. Especially in light of the Health Resource Allocation Plan's data about workforce shortages in Vermont's health care system, how, specifically, will VDH use a conceptual CON to determine:
    a. Staffing needs at replacement facilities
    b. Recruitment and hiring practices and policies related to meeting such staffing needs
    c. Ensuring that the current workforce at VSH, described in the application (p. 26) as "uniquely qualified, by virtue of experience and training, to provide specialized and intensive psychiatric inpatient services in the future", is utilized for the good of patients in need and for the good of the State

64. The application (p. 26) concludes a section about the VSH replacement by indicating "the capacity at VSH needs to be replaced with new inpatient and community programs that are responsive to current and future needs of Vermonters in need of mental health service." The importance of community programs as a critical part of the plan to replace VSH is referenced throughout the application. One such reference concerns the actuarial projections of bed need, indicating different levels of bed need depending on the extent to which community programs are implemented.

    In order for the Public Oversight Commission to make findings and recommendations on VDH's CON applications (both Conceptual and Phase II), and for the Commissioner of the Department of Banking, Insurance, Securities and Health Care Administration (Commissioner) to issue decisions on the applications, they will have to know the extent

to which the community programs will be implemented. How, and when, will VDH determine this and provide the information?

65. What is meant by "isolation of the program from the rest of the inpatient care system" (p. 26) and how, both in terms of facilities and programming, will the proposed plan positively address this issue?

66. The application calls for Vermonters hospitalized for acute psychiatric inpatient care to "have access to the same diagnostic and treatment facilities as all other Vermonters."
    a. Does this level of access require that all such needed diagnostic and treatment services be provided at Vermont's only academic medical center and tertiary care facility (FAHC)? Please explain.
    b. Does this level of access require particular diagnostic and treatment services be provided at FAHC? Please explain.

67. The application indicates stigma would be eliminated (p. 26) by implementation of the project.
    a. How does VDH define stigma in this context?
    b. Please explain the extent of the current stigma problem and what factors are believed to contribute to it.
    c. What does available research indicate as effective ways to eliminate or reduce such stigma?
    d. How would implementation of the project eliminate or reduce such stigma?

68. Regarding the goals expressed on page 27 of the application:
    a. How would achieving those goals (please respond separately regarding each one) address particular findings by the Department of Justice regarding care at VSH?
    b. How will replacing the VSH facilities serve to achieve those goals?
    c. To what extent is achievement of the goals not dependent on construction of particular new or renovated facilities but rather on changes to systems, programs, policies, practices, training, staffing, protocols and so forth?

69. Please define and describe what VDH means by "secure residential facility" (e.g. page 28) and indicate:
    a. How many beds VDH believes the secure residential facility will require for each year from 2010-2020
    b. Where such beds would be located and in what type of facility(ies)
    c. What entity(ies) would fund, staff, and govern such beds, and how, and
    d. How the care provided in such beds would meet the goals described throughout that application such as the goals of providing integrated care and ensuring access to care that is the same as all other Vermonters have access to

70. The application references (p. 28) a recommendation of "Locating services in or near the most appropriate setting: academic medical centers, community hospitals, or other community based facilities" but does not indicate preferences for particular academic medical centers, community hospitals or community based facilities or how to prioritize

them. Please specifically explain the process and rationale that resulted in the application recommending construction of replacement VSH facilities at or in conjunction with one of the two academic medical centers that serve Vermont. Please provide documentation and other materials needed to put the reply in context.

71. Please describe the "thorough clinical and operational planning process that includes the State's hospitals." (p. 28) If this has not been accomplished please explain how the conceptual CON will be used to accomplish this.

72. Regarding the crisis beds referenced throughout the application (e.g. p. 29):
    a. How does VDH define such crisis beds and what is their role in the system of care?
    b. How many such beds exist now and where are they located?
    c. How many such beds does VDH plan to implement as part of the project?
    d. Where will they be located and/or what factors will determine location?
    e. How does the successful implementation of the crisis beds impact the projected need for ICU, SIC and general inpatient psychiatric beds to replace VSH?
    f. How will be the crisis beds be coordinated and integrated into the inpatient psychiatric system of care?

73. The Futures Plan is presented on page 29 as including (item f) the "enhancement and sustainment" of eight "existing delivery system elements". Please provide:
    a. A status report on each of these elements
    b. An explanation of how VDH expects to enhance and sustain funding for components 1 through 7 while also funding the project to replace the facilities and relocate the services of VSH

74. How will implementation of this project improve the following problems identified in Secretary Charles P. Smith's report of February 4, 2005 (p. 30):
    a. "…services are not well coordinated across the continuum of mental health care, from primary care providers to the community partners, to the designated hospitals, to the VSH and prisons…"
    b. "…the community mental health system has faced increasing demands for service, with limited funds allocated for cost of living and inflationary pressures."
    c. "…many Vermonters in need are not receiving services."

75. Why does the plan call for new inpatient programs at a primary and secondary location "be operated under the license of host hospital(s)" rather than under the license of the State?

76. Regarding legal services, both civil and criminal, needed by patients at Vermont State Hospital:
    a. Please describe the scope, funding, and processes for providing such services currently
    b. Please describe how the scope, funding and processes for providing such services will need to change if the project is implemented as planned

c. Please describe VDH's plans to accomplish the needed changes

77. What degree of physical co-location of services is required to achieve the recommendation set forth on page 31 of the application that "The current state hospital facility should be replaced with a facility or facilities with fewer than 54 beds and with meaningful programmatic integration of medical and community mental health services."?

78. The application indicates plans for and a need for a secure residential treatment facility but it appears inconsistent as to how many beds are needed in such a program, calling in some places for 6 such beds and in other places for 8 such beds (see, e.g. page 32 and appendix A. Also see pp. 67-68 where it indicates a need for six secure residential care beds to serve "four to eight individuals at any given time"). Please explain.

79. Please explain the role the Department of Corrections (DOC) has played to date in the development of the project and indicate:
    a. If the DOC has approved or endorsed the application
    b. How the VDH and the DOC will partner to implement the project

80. Please explain how the project will "incorporate the needs of certain populations served by the Department of Corrections"? (p. 81)

81. Please explain how the project will address the identified need for new supportive housing resources: "consistently identified …as one of the most significant unmet needs of Vermont's citizens with mental illness." (p. 34)

82. Please explain how success in addressing the housing need identified on page 34 of the application will impact the need for replacement beds for VSH. Specifically, has VDH been able to quantify, or does it have plans to research and quantify the relationship between housing supply and need for inpatient beds?

83. The application indicates (p. 34) that planning for the inpatient and community services "needs to occur in the context of considering the overall financial health of the designated hospital and agency service providers." Please either provide documentation of such planning conducted by VDH or indicate what the plan is to conduct such planning.

84. Please describe the Health Care & Rehabilitative Services (HCRS) "program for cost-effective management of pre-CRT individuals" noted on page 34 of the application, explain what resources will be needed to implement the called-for replication of that program in other areas of the state, and indicate how the resources will be obtained and the plans implemented.

85. How will the other enhancements noted on page 35 of the application (expansion of the co-occurring disorders project, public health prevention and education strategies, and offender out-patient services & mental health plan for corrections) be resourced and implemented?

86. Please provide the VSH strategic plan referenced on pages 35-36 of the application.

87. Please provide the referenced "analysis of the options for inpatient partners" that was conducted (p. 36).

88. Please explain how VDH conducted the referenced "consideration of costs including the IMD issue". (p.36)

89. Please explain the limitation of consideration of "interest of potential partner(s) to provide specialized inpatient psychiatric care". Does this mean potential partners' interest in providing general inpatient psychiatric care was not considered? Please explain.

90. How did VDH determine "ability to attract and retain staff? (p. 36)

91. How does VDH define the "necessary critical mass to develop a strong program" and how was this determined? (p. 36)

92. Regarding Northeastern Vermont Regional Hospital's interest in and ability to partner with the State to provide inpatient psychiatric care (see, e.g. p. 37) please document:
    a. any requests to NVRH that it consider operating "VSH replacement inpatient services"
    b. any responses from NVRH regarding operating "VSH replacement inpatient services"

93. Please document Central Vermont Hospital's (CVH) response(s) to VDH's inquiries regarding CVH's interest in participating in the project, both with respect to provision of mental health care and physical health care.

94. The application notes, on page 39, that "Medicaid payments for inpatient psychiatric care at general hospitals were not affected by [the IMD] policy change because they were *not* classified by CMS as IMDs." (emphasis in original). Please explain:
    a. For FAHC and RRMC, what percent of the hospitals' costs for inpatient psychiatric care were reimbursed by Medicaid in hospital fiscal years 2004, 2005 and 2006 (projected).
    b. How implementation of the project would affect the percent of the hospitals' costs for inpatient psychiatric care to be reimbursed by Medicaid
    c. How implementation of the project would affect the payment of the hospitals' costs for inpatient psychiatric care for Medicaid patients

95. Is "simultaneous access to psychiatric and physical health care" (p. 39) the standard of care? Please explain.

96. Given that Northwestern Medical Center (NMC), Brattleboro Memorial Hospital (BMH) and Southwestern Vermont Health Care (SVHC) are located within reasonable commuting distance to hospitals with significant inpatient psychiatric care programs

(FAHC, Retreat HealthCare and Albany Medical Center, respectively) how and why has VDH concluded (p. 45) that "it would be difficult for" NMC, BMH and SVHC to "develop program and staff infrastructure required to operate psychiatric inpatient care at the specialized program level?"

97. The application presents capacity assumptions of 90% and 95% (see, e.g. pp. 45 and 57), discusses a need to have adequate "surge" capacity (see Appendix A, for example, the Request for Information, which indicated a need for "sufficient 'surge' capacity to meet expected spikes in demand), and notes that VSH, and its replacement facilities must have a "zero reject" policy.
    a. Given the need for the zero reject policy in order to ensure needed treatment for the most seriously mentally ill patients and to meet the public good, why is the VDH not planning to be able to meet 100% of projected capacity?
    b. How will the VDH and its partners serve those in need at times when the planned-for capacity of 95% is filled?

98. Regarding Table 7 on page 47, it appears the non-mental health average daily acute care censuses were not adjusted, as were the mental health average daily acute care censuses, to account for utilization growth between 2004 and 2014. Either explain that this has been factored in or revise the table to include a column for "all other acute care ADC 2014" in between the columns for "Total MHADC 2014" and "Total ADC 2014".

99. How did VDH "[solicit] the interest of all of Vermont's hospitals"?

100. What, if anything, did VDH do to solicit interest from hospitals in neighboring states with a presence in the Vermont health care sector?

101. Regarding the Request for Information (appendix A) issued December 16, 2004 with a due date of December 31, 2004, it is noted that some respondents cited the difficulty of responding to such a request during last two weeks of the year. This included the period of the Christmas and New Year's Eve holidays. It also appears some of the responses were cursory in nature (citing the timing of the RFI as a reason) when responding to the "guidelines for respondents". Given these factors:
    a. How valuable does VDH believe the responses are as a gauge of interest in providing the services needed?
    b. Did VDH follow a process to mitigate the potential negative impact of the timing and timeline referenced above?
    c. Please explain why the responses from FAHC, RRMC and Retreat Healthcare are dated on or before the RFI issue date of December 16, 2004.

102. Please document the statement in the application that "The leaders of Vermont's inpatient psychiatric programs feel it will be extremely difficult for a hospital without experience in these areas to create such a program…" and identify these "leaders". (p. 51)

103. Regarding Table 9 on page 52 of the application:

a. Why hasn't a process been developed to weigh the relative values of each criterion?
b. Without knowing the relative value of each criterion how has VDH compared potential options against each other?
c. Why is FAHC (second column from the left) rated as "High-Medium" in terms of retaining the current VDH workforce?
d. It appears the Table is in error in that FAHC is rated as "High" (meaning most likely to meet the standard) with respect to "Lowest Capital Construction Cost". Indeed, all the grades in the row marked "Lowest Capital Construction Cost" appear to be in error when compared with the cost estimates presented in the body of the application. Please review and explain.
e. Why is a "single program state run" rated "Low" in terms of "System design creates a 'critical mass'"?
f. Please explain the apparent inconsistency between the statements that the "schematic is presented without any attempt to weigh or assign values to the various dimensions" (p. 51) and that "As the Table indicates… Fletcher Allen Health Care and Rutland Regional Memorial Hospital present the best option…"
g. In light of the statement on page 52 that "Partner input has not yet occurred with respect to developing the cost estimates and potential operating savings associated with co-location", what are the cost criteria valuations included in Table 9 based on?

104. The application indicates (p. 52) that neither FAHC, RRMC, nor the Retreat have "agreed to any of the project cost estimates herein." Please indicate:
a. Whether FAHC, RRMC and/or the Retreat have reviewed and/or provided feedback on such cost estimates. If so, please provide the documentation..
b. Whether FAHC, RRMC, and/or the Retreat have conducted, or caused to be conducted, project cost estimates. If so, please provide the documentation..

105. Regarding Construction Costs (p. 53, et.seq.):
a. What are the "various sites" Architecture Plus conducted preliminary assessments of?
b. How, why, and by whom, were those sites selected?
c. Please provide all documents containing Architecture Plus' cost estimate information
d. Please explain and document the "different methodologies" Architecture Plus used (see p. 53)
e. Please explain and document the "very limited input" Architecture plus received from FAHC and RRMC. Also, was any input received from the Retreat? Please explain.
f. Why does the estimate for a 40 bed integrated facility at FAHC indicate it includes a cost for "replacement parking"? What parking will need to be replaced?
g. Why is the cost estimate for the 40 bed integrated facility higher than the cost estimate for the 40 bed stand alone facility?

h. Under the "68-bed integrated facility" model, what has been communicated by FAHC, or anyone else by or on behalf of FAHC, would become of the current FAHC inpatient psychiatric care facility?
i. Do the cost estimates presented include:
    i. Soft costs
    ii. Capitalized interest
    iii. Demolition costs
    iv. Relocation costs
    v. Backfill costs
    vi. Equipment
    vii. Furnishings

106. What cost estimates, if any, has VDH done, reviewed, or become aware of concerning the provision of such ancillary services as diagnostic, lab, laundry, food, or other needed facility services on each campus being considered? Please explain.

107. Table 11 (p. 57), regarding projected bed need for adult mental health inpatient care, indicates there would be a decreasing need for SIP beds and general beds as implementation of community resources increases. It does not, however, indicate any change in the need for ICU beds. Please explain.

108. The application indicates that a reason Dartmouth Hitchcock Medical Center is not an available resource to replace VSH bed capacity is because DHMC's patients are voluntary.
a. How is this relevant to future planning to replace VSH?
b. Are FAHC, RRMC and the Retreat's current patients voluntary and/or involuntary? Please explain.

109. The application indicates the project would create a bed capacity in 2012 that would range from 157 to 167 beds and "permit expansion-contraction as needed." (p. 57)
a. Please update the bed projection, and the data on Table 12, to reflect need through 2016
b. Please indicate how each of the project's inpatient components, as currently contemplated on the FAHC, RRMC, and Retreat campuses, could permit expansion, both in terms of facilities and programs. Please respond separately as to each campus.

110. Regarding Table 12 on page 58:
a. Are the psychiatric beds referenced licensed separately or distinctly from other beds in each of the hospitals listed? Please explain.
b. Why are the Veterans Administration beds projected to decrease in number?
c. Why are the CVH, FAHC, RRMC, Retreat, and DHMC beds not projected to increase in numbers over a ten year period except for a one-for-one replacement factor to accommodate for the closing of VSH?

111. What role does the Veterans Administration hospital (VA) inpatient psychiatric unit play in the continuum of care available to Vermonters with serious mental illness and how do the VA and VDH coordinate such care?

112. In preparation for replacing or improving VSH, has VDH obtained any information regarding how other states, both in terms of facilities and programs, serve their patient populations most similar in need to the patients at VSH? If so, please explain and provide supporting documentation.

113. The application indicates that "As an isolated, stand alone unit VSH cannot meet the quality standards for best practices for mental health service delivery." (p. 60).
   a. Is it VDH's conclusion that it is impossible for isolated, stand alone units to meet quality standards for best practices for mental health service delivery? Please explain.
   b. Is VDH aware of any isolated, stand alone units that currently meet quality standards for best practices for mental health service delivery? Please explain.
   c. Please provide source information and documentation of the referenced quality standards for best practices.

114. What is meant by "a public/private partnership between the State of Vermont and three of Vermont's private general hospitals."? Please outline the rights and responsibilities of the parties under the partnership.

115. Please describe the current legal and management relationships, including rights and responsibilities, between the Designated Hospitals and the State. How does VDH "ensure that clients' rights are protected, that the custodial role of the state is appropriately carried out" and that "clear and enforceable contracts with service providers are developed and maintained"? (p. 68)

116. How will co-location of inpatient psychiatric beds at FAHC enhance "exploration and testing of new ways for other health professionals to serve individuals with severe and persistent mental illness and co-occurring disorders" in ways not possible currently pursuant to the contract FAHC has with VDH to supply psychiatric health care professional services to VSH? (p. 62)

117. Similarly, how will co-location of inpatient psychiatric beds at FAHC enhance "education and training opportunities for an array of health and mental health professionals" in ways not possible currently pursuant to the contract FAHC has with VDH to supply psychiatric health care professional services to VSH?

118. How will the project help alleviate the identified (p.63) shortage of adult and pediatric psychiatrists?

119. Please elaborate on the project's interaction with and relationship to the Vermont Blueprint for Health (Blueprint), the Chronic Care Model (CCM), the Futures Care

Management (FCM) System (all referenced in the application), and the Vermont Information Technology Leaders (VITL).

120. Please explain how the project's components will integrate or be integrated and compatible with the Blueprint, CCM, FCM, VITL, and each hospital's existing and/or planned systems regarding:
    a. Clinical information, including but not limited to patient health records
    b. Care management
    c. Management systems
    d. Financial systems, including but not limited to billing
    e. Quality measures, both process and outcome based
    f. Accreditation
    g. Compliance
    h. Privacy
    i. Quality improvement

121. Please provide a replacement of Table 14 prepared and reproduced in such as way as to facilitate review.

122. Regarding the sustainability of "Designated Agenc[ies]" referenced on page 69 and the five programs cited, please clarify whether the Designated Hospitals are considered Designated Agencies. Please explain.

123. One of the responses to the Request for Information (appendix A), the response from the Northeast/Central Collaborative, (hereinafter the NCC), consisting of The Clara Martin Center, Northeast Kingdom Human Services and Washington County Mental Health Services, particularly proposed resources to address needs in the central and northeastern part of Vermont, regions it appears are addressed in the application less directly by the proposed plan than are the northern and southern regions of the state. The NCC also indicated a history of working collectively with Central Vermont Hospital, Gifford Hospital, Northeastern Vermont Regional Hospital, the Dartmouth Hitchcock Alliance and the Veterans Administration Hospital, facilities serving the central and northeastern regions of Vermont. Given that FAHC, RRMC and the Retreat are generally identified as serving the northern and southern regions of the state, please describe any follow-up the State has conducted with the NCC or its members or the referenced hospitals to further meet the needs in central and northeastern Vermont.

124. The response by the Howard Center for Human Services (the Howard) to the RFI echoed concerns expressed in the NCC response regarding past failures by the State to fund community-based programs designed to help move services from more institutional settings. What is VDH's response to these concerns?

125. Does VDH agree with the following assertions in the Howard's response to the RFI? Where questions are included within the quoted text please respond to those questions:

a. "minimum VSH hospital based bed capacity must be maintained at no less than the current levels. Though step-down and sub-acute services expansion as well as enhanced peer services models, over time, may demonstrate an ability to reduce such capacity, it would be premature in the planning stage to construct a service model on an unproven assumption."
b. "Our experience …would suggest that significant change will be necessary in order to actualize an efficient system that is not confronted with patients in need of voluntary or involuntary admission and bed-based providers unwilling to accept them."
c. "…the RFI …appears to represent a significant expansion (with regard to TBI, DD and, to some extent, trauma) of populations currently served at VSH." "…adults with SPMI are funded through the Medicaid Waiver Case rate system, while clients in the DD population are served on an individual waiver basis. Will the change in modeling capacity necessitate changes in either or both waiver models? Will funding for all clients/patients be consistent across diagnostic categories?"
d. "Any change in the location of VSH beds will no doubt exacerbate an already critical problem in housing in the Burlington area. Supervised apartments, shared-living arrangements, group homes, transitional housing and community care homes are all inadequate to meet the current need and contribute, in no small part, to the 'back-up' in the movement of clients throughout the system. Any transformed system must address this end of the service spectrum with the same vigor as acute bed access."

126. The response by the Retreat to the RFI proposed adding a 16 bed acute care unit that could serve 10 general psychiatric acute care patients and six patients in need of psychiatric intensive care. The Retreat also indicated this unit could flex between the two needs. Why does the project as proposed only plan on adding 4 beds at the Retreat, none of which would be at the intensive care level?

127. The response by FAHC to the RFI proposed the "managing and/or staffing of a state-owned inpatient psychiatric facility…constructed and operated with state funding." Why does the project as proposed not plan for the facility at the FAHC campus to be state-owned?

128. The application states that the options ("preferred options, p. 2") being presented "are the result of multi-stakeholder study and input," (p. 1) and that the plan "has been developed by a multi-stakeholder advisory committee that has met for over two years." Please identify and attach any specific portions (in sufficient context) of minutes, or motions and recorded votes, of any multi-stakeholder group, the Futures group, or a Futures work group which provides input regarding, or proposes development of:
a. a "preferred option" of a program operating under the license of Fletcher Allen Health Care (FAHC)
b. an addition of licensed beds at the Rutland Regional Medical Center (RRMC)
c. renovation and/or expansion of the psychiatric programs at RRMC

d. renovation and/or expansion of the psychiatric programs at Retreat Healthcare (Retreat)

129. The application states that the Futures Advisory group "strongly endorsed" the recommendations of the Inpatient Work Group regarding primary and secondary inpatient partner criteria, and that these recommendations were accepted by then-Secretary of the Agency of Human Services, Michael Smith (pg.7). Please supply the minutes and the motion(s) as voted on by the Futures Committee, specifically including any changes or additions made from the recommendations forwarded by the Inpatient Work Group. In addition, please provide documentation regarding the recommendations that were accepted by Secretary Smith.

a. Please describe and explain any subsequent actions, including modifications, by the Agency of Human Services regarding such endorsement of these recommended criteria and conditions.
b. Please describe and explain the ways in which the three hospitals identified under the "preferred options" have been assessed and demonstrated to meet each of the criteria. Please include a matrix setting forth all of the criteria and indicating to what extent each of the three hospitals meets each criterion.

130. The application references the settlement with the Department of Justice (DOJ) as part of the current issues affecting the Vermont State Hospital.

a. Please file copies of the DOJ complaint as filed in federal court, all findings, and the settlement agreement.
b. Please file the memorandum provided by Wendy Beinner, Esq. to the Mental Health Oversight Committee on August 17th, 2006 regarding the "Terms of Agreement between the United States Dept. of Justice and the State of Vermont and please:
    i. specifically explain how the following health care issues identified in that document would be resolved by granting permission for VDH to replace the Vermont State Hospital:

        1. integrated treatment planning
        2. mental health assessments,
        3. discharge planning and community integration,
        4. monitoring of specific treatment services for safety, effectiveness, and appropriateness, particularly use of psychotropic medications,
        5. documentation,
        6. use of restraints, seclusion and emergency involuntary psychotropic medications,
        7. protection from harm,
        8. incident management,
        9. quality improvement, and
        10. identification, of environmental safety hazards, including potential suicide hazards; and screening of contraband.

ii. specifically explain how the following health care issues identified in that document can be resolved in the current Vermont State Hospital. If VDH contends it is impossible to resolve any or all of these issues in the current Vermont State Hospital please explain, specifically:
    1. integrated treatment planning,
    2. mental health assessments,
    3. discharge planning and community integration,
    4. monitoring of specific treatment services for safety, effectiveness, and appropriateness, particularly use of psychotropic medications,
    5. documentation,
    6. use of restraints, seclusion and emergency involuntary psychotropic medications,
    7. protection from harm,
    8. incident management,
    9. quality improvement, and
    10. identification, of environmental safety hazards, including potential suicide hazards; and screening of contraband.

131. The application at various times references the mental health service system, and the public mental health services system. (See, e.g., p.10) Please explain the distinction that results in a person being served by one system or the other, specifically including inpatient care, and explain why an individual is served at VSH or a "designated hospital" under the care and custody of the Commissioner, in comparison with other persons who are also admitted to general psychiatric units in the state's "designated hospital" network.

132. Based upon the answer to question 132 above, how do the tables for per capita use of inpatient psychiatric care (pp. 13-15) relate to the forecast in need for capacity for patients currently served at VSH? Please supply data that contrasts the episodes of hospitalization, the patient days, and the unduplicated number of people served for all inpatient care provided to Vermont residents over the past 5 years with the same data for persons being served under the custody of the Commissioner (whether at VSH *or* at a designated hospital.) How do the rates of growth of each of these groups relate to the rates of the growth in population?

133. On page 11, the application states that partnership with designated hospitals has resulted in a "significant shift in the number of involuntary admissions away from VSH." Please provide the data showing the outcomes of this shift, and how VSH bed use has changed if the census has remained stable despite this shift in admissions.

134. Does VDH have any data to indicate why utilization of VSH has "been consistent for the past ten years" (page 17)? For example, is it because the need for its services has remained level, because the facility has been consistently close to capacity and other hospitals have been utilized to provide services that used to be provided at VSH, or because community programs have re-directed care from inpatient to outpatient? Please provide any and all data that support your conclusions.

135. The application states that Rutland is licensed for 19 beds, but has an actual capacity of "10-12." The application also provides information about capacity, both psychiatric and non-psychiatric, at VSH and other hospitals. The information is not consistently presented, however, so as to compare among licensed beds, staffed beds, beds dedicated to psychiatric care, and beds dedicated to non-psychiatric care. Please revise the tables (see, e.g. table 4 on page 37) and/or create new tables, to clearly indicate and compare the numbers of *licensed* and the number of *staffed* beds for psychiatric and non-psychiatric care at all of the hospitals referenced, including Vermont State Hospital. Likewise, please review the fourth paragraph on page 37 and explain the connection between the references to "total acute care staffed beds" and the "total licensed acute care beds" contained therein.

136. With respect to VSH:

a. Does it actually have beds, bedrooms and/or living accommodations for 54 individual patients to be served simultaneously?
b. How many times from July 2002 through June of 2006, by month, did VSH reach this maximum physical capacity?

137. The application makes references to patients at VSH as having the "highest acuity" among psychiatric inpatients.

A. How is acuity defined clinically?
B. Is there a direct clinical relationship between acuity and the need for security?
C. If so, please provide clinical substantiation.
D. Among those patients generally described as "forensic" patients because they have been referred by the courts, is there consistently the same level of acuity? Please explain.

138. On page 18, the application states that designated hospitals can now accept forensic referrals.

A. How many such referrals have been admitted to a designated hospital since January 1, 2006?
B. Does the Division expect this figure to increase? Why or why not?
C. What percent of current forensic admissions per month at VSH might not be in need of the "specialized" level of care provided only there, and could be served in a designated hospital's inpatient unit?
D. Has this projection (from c above) been taken into account in assessing the needed bed capacity for VSH services in the future? If so, how? If not, why not?

139. The application states (p.18) that a person is currently only admitted to VSH on an emergency exam if all four designated hospitals have been unable to accept the patient.

a. Please identify the number of persons, per month, since January 1, 2004, who were admitted for an emergency examination at the first designated hospital contacted for admission, at the second referral, at the third referral, and not until the fourth referral.

b. Among those admitted at the third or fourth referral, please identify their home county and the distance that hospital was from their home county.

140. The application (page 18) states that Vermont has "an important opportunity to plan for replacement services that are voluntary," stating that some of the care currently delivered at VSH could probably be delivered voluntarily if other options were available.

a. If the current inpatient care at VSH has a capacity of 54, and the replacement options proposed in this application include 50 beds (page 57), all of them ranging from secure "specialized" to high security "intensive care" beds, please explain in what aspect the Department has developed a proposal that creates *replacement* services that are voluntary.
b. Alternatively, in describing 18 "subacute" and six "secure residential" beds as being *"relocated from VSH"* (page 67), why would it not be considered that this proposal is actually seeking to increase the (remaining) capacity from 30 to 50?
c. In what ways does the proposal support state law and policy to reduce coercion in the system?

141. The application notes that the "relative strength of the community services infrastructure directly impacts the use of psychiatric inpatient care," (p. 19) thus acknowledging that the scope of the Futures plan and implementation of it is integral to identifying the level of need for replacement inpatient beds. In what specific ways does the VDH expect to demonstrate in a future CON application that the system has maximized the ability to provide voluntary and community-based alternatives?

142. The application cites a need for specialized and intensive care beds higher than at the level Milliman cites under "full implementation" but the application states at page 59 that "The number of beds proposed for the inpatient psychiatric facilities that are the subject of this Conceptual CON Application rest on the assumption that the Futures plan will be fully implemented." Please explain this apparent discrepancy.

143. The application states on page 17 that there are three "forensic" categories for admission to VSH, each involving persons in need of inpatient care.

a. Do any such individuals remain at VSH after they are no longer in need of inpatient care? If so, in which categories?
b. Who makes the decision to not discharge the individual from inpatient care?
c. Does the VDH propose any changes in law, rule procedure or policy that would place more control with an inpatient facility regarding when its clinical services are needed in such cases?

144. For each of the three categories of forensic care, please provide data for the past ten years on the rate of growth or decrease in that category. Specifically note the rate of persons charged with a criminal act who are referred as inpatients for competency evaluations as compared to the increase or decrease of all persons charged with crimes; the rate of findings of not guilty by reason of insanity and rates and lengths of stay of resulting inpatient hospitalization; and the rate of incarceration in the population as compared to the rate of persons who are incarcerated and are referred for inpatient care.

Please explain how the future needs for the incarcerated population will have been adequately assessed and addressed through the actions proposed by VDH.

145. Is the assumption on page 25 that patients currently in need of an "intensive" level of services and being served at VSH would require fewer emergency interventions such as restraint and seclusion if the physical facility were different? Please explain. Please include any citations to support such assumptions.

146. How will the preferred options support the policy objectives of the Vermont Health State Plan to enhance integration of care "by physically locating inpatient mental health services with medical services" (page 28), if the preferred option that is developed is "off the campus" of Fletcher Allen Health Care?

147. Regarding Northeastern Vermont Regional Hospital (NVRH):
   a. Has the VDH explored further Northeastern Regional Hospital's possible interest in "developing a general psychiatric inpatient program as a way to better serve their community" (p. 37) as part of its directive to plan for replacement of services for VSH "within...a comprehensive continuum of care"? Please explain.
   b. How are the access needs of Vermonters to inpatient mental health care from its service areas currently being met? Please provide data contrasting regional access needs, based upon inpatient hospitalization rates and number of inpatient psychiatric beds currently available, that would be met by 10 additional general psychiatric inpatient beds in Rutland versus 10 general psychiatric inpatient beds at Northeastern.
   c. What would be the impact of a 10 bed program at NVRH on the need for new beds at FAHC?

148. Please provide the citations that define whether a "facility," as the term is used by the application in defining IMD determinations on page 38, means a specific building, cluster of buildings, or can include buildings that are on different campuses and serve different medical specialties; and similarly whether "within general hospitals" means inside a physical structure versus within a corporate structure.

149. Please provide copies of all documentations relied upon by VDH to reach its conclusions regarding the IMD exclusion.

150. Please provide copies of all communications to or from VDH regarding the IMD exclusion, including but not limited to communications with the Centers for Medicare and Medicaid Services.

151. Please provide copies of all documentations relied upon by VDH to reach its conclusions regarding "provider-based status" (pp. 39-40).

152. Please provide copies of all communications to or from VDH regarding provider-based status, including but not limited to communications with the Centers for Medicare and Medicaid Services.

153. What are the "limited exceptions" set out in regulation to the "35-mile radius" rule noted in the application at page 4?

154. Table 5 (p. 42) regarding the sources of funds for inpatient psychiatric care is helpful but to better understand the funding issues at VSH and compare them to those at each of "Vermont's community and tertiary care hospitals" (p. 41) please provide a matrix or chart illustrating the funding amounts and sources, from July 2000 though the present, including the following (at VSH, at each of "Vermont's community and tertiary care hospitals", and at Retreat Healthcare):

a. percentage funding by Medicaid
b. percentage funding by other federal sources (explain)
c. percentage funding by other governmental sources (explain)
d. percentage funding by third party payers (explain)
e. percentage free care
f. percentage bad debt
g. percentage self pay
h. other (explain)

155. What has VDH done, or does it plan to do, to explore other options, including but not limited to:

a. upgrading the existing facility
b. building a new facility on the Waterbury campus
c. purchasing an existing facility
d. building on available land at or near other hospitals

156. What implications would this proposal have on the Medicare cost reports of FAHC, RRMC, and the Retreat?

157. Does the State have an agreement(s), either in principle or in writing, with FAHC, RRMC and/or the Retreat in furtherance of the project? If so, please submit documentation.

158. Please provide specific information on the decisions made in other states with respect to closing state hospital programs. Have any other states given up complete control of all their inpatient facilities?

159. Has VDH consulted with experts on the provision of inpatient psychiatric care? If so, please submit their reports and recommendations.

160. Is the VDH aware of concurrent interest at one or more Vermont hospital(s) to develop new general inpatient psychiatric bed units? Please explain.

If you have any questions please call me at 802-828-2963.

Sincerely,

Bruce Darwin Spector, Esq.
Chief Legal Counsel

Cc: Project file
Interested Parties